LTC 2001 Business Plan

Issues/Uncertainties
- Medicare/Medicaid reform
- Zeldox launch timing & label
- Competitor rebates & LTC pharmacy change orders
- Zyprexa anticholinergic & hyperglycemia misinformation
- Ability to align internal sales & marketing teams in a
- Data incongruity/distractions
- Corrections/Institution strategies
- SOP for LTC
- Rollout of Premier Reward
- Post Prozac patent activity/weekly

Key Trends
- Fastest growing segment of the market
- Aggressive pricing/rebating by competitors
- Hypercompetitive market; inc. spend (people & promotion)
- Brand commoditization

Strategic Intent
- Exceed Sales/BUC targets on both Zyprexa & Prozac
- Expand/develop people
- Establish Lilly as an industry model for Long Term Care

Strengths
- Profile & spectrum efficacy for Z&P
- Grass roots build equals greater customer/business acumen and a competitive advantage

Opportunities
- New Rep & Mgrs training & growth
- Zyprexa IM launch& Zyprexa Zydis
- Leverage market/customer knowledge during SF expansion
- Maximize selling resources & new brand data
- Partner with customer treatment teams to increase Rxs
- Prozac Weekly
- Hire talent, expand C/P knowledge & increase selling skills
- Immediate patient conversion potential in NH
- Integrate Brand, Sales, B2B, & Medical to maximize BUC
- Expand and make consistent SOPfor clear direction

Critical Success Factors
- Staffing/Development & retention of reps & mgrs.
- Discipline to focus/balance on targeting & sales
- Establish Zyprexa as primary mood stabilizer, upgrade patients from competitors, and solve issues
- Maximize Prozac's geriatric indication (TUF pt)
- Appropriately balance Prozac and Zyprexa
- Effectively blunt Zeldox and other competitors
- Insure unrestricted availability & B2B link
- Optimize Reward & Recognition early to drive sales and retain key talent

Putting the LTC Puzzle Together

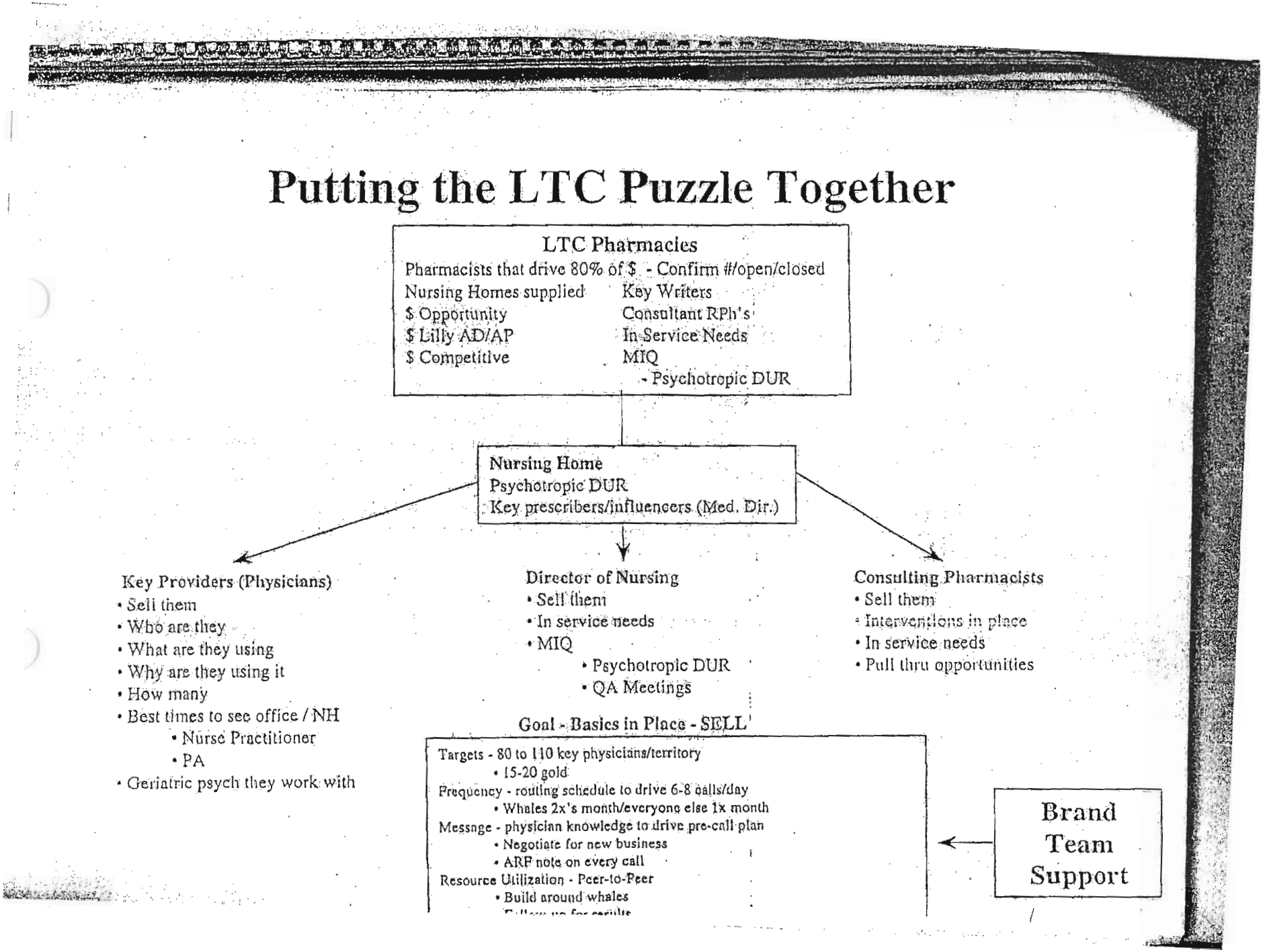


EXHIBIT B

Dear Doctor,

This resident is receiving Zyprexa 2.5 mg daily at ____ am/pm. Current geriatric studies demonstrate that Zyprexa provides superior efficacy and safety when compared to placebo and significantly reduced caregiver burden at a dose of 5mg daily[1]. Zyprexa has also demonstrated superior efficacy in treating active, passive, and verbal aggression, as well as hallucinations and delusions[2]. Please consider upgrading this resident's treatment to 5mg daily at 5 p.m. to optimize their therapy.

---

[1] Street JS, Clark WS, Gannon KS, et al. 2000. Olanzapine treatment of psychotic and behavioral symptoms n patients with Alzheimer's disease in nursing care facilities: a double-blind, randomized, placebo-controlled trial. Arch Gen Psychiatry 57:968-976.
[2] Edell et al

Dear Doctor,

This resident is receiving Zyprexa ___ mg ___(QD, BID) at ____ am/pm and either has difficulty swallowing or has a G-tube. Zyprexa Zydis is a new formulation of Zyprexa that is an orally disintegrating tablet that can be placed on the resident's tongue or dissolved in water to be administered via G-tube. Please consider upgrading this resident's therapy to Zyprexa Zydis___ mg ___(QD, BID) at ____ am/pm to reduce the nursing time and effort required to administer this resident's medication therapy.

EXHIBIT C

To Lilly Human Resources Department:

Listed below is documentation regarding my manager, Dan Tubridy. As you will see, Dan's behavior during his tenure as Sacramento District Long Term Care District Manager since early 2001 has been somewhat unprofessional. He has displayed favoritism toward the men of the team and made the women feel unappreciated, undervalued, and uncomfortable. At this point, I have no respect for this manager and feel quite uncomfortable and demotivated reporting to him. His values clearly do not reflect those of Eli Lilly: particularly Integrity and Respect for People. As a result, I have decided to share this information with the company's Human Resources Department.

June 19, 2001
Sales meeting in Las Vegas, NV

Most members of our team (Beth Merino, Holly Burkhart, Tanya Calandra, Tremell Turner, and Bryan Zappulla) went out for refreshments at Caesar's Palace after dinner. We stayed and enjoyed each other's company for a couple of hours. The women of the team noticed that Dan had taken his wedding ring off sometime during the evening and left our table to attempt to create conversation with some women who were seated near us. While Dan's choice of what to do with his personal time is his own, he was completely unaware of the image he was creating for himself by exhibiting this behavior in the presence of his new subordinates.

Around midnight Dan asked Tremell and Bryan to break off with him to go someplace else without the women of the team. As we were all new to the team and wanted to make a good impression with our new manager, Tremell and Bryan agreed to go with Dan. Dan kept them out until 5:30 a.m. the next morning. Dan called me early the next morning and asked me to contact the rest of the team to announce that our meeting would be starting an hour later than scheduled. When the meeting finally did begin, the three were terribly exhausted and unable to concentrate. I was scheduled to give my first team presentation that morning, although I had to cut it short since we were now short on time. I gave my presentation, although many were not able to concentrate. One person actually fell asleep while I was presenting. We later learned that Dan had taken the three of them to a "gentlemen's club" where they passed the night away. This set the tone in our minds (the women of the team) as to the level of respect that Dan has for women in general. We have felt quite uncomfortable around him ever since that evening. We also felt that this behavior was extremely unprofessional for a manager as it clearly interfered with the progress of our meeting and our (the women of the team) level of respect for him as a manager.

Week of January 7, 2002
Territory Overviews with Dan

Those of us who live near the Sacramento district office (Beth Merino, Maggie Bolton, Tanya Calandra and myself) were all scheduled to drive to the office for a territory overview with Dan. For Tanya, this was actually a three-hour drive. Although Bryan Zappulla livedonly a 45-minute drive away from the Sacramento office at the time, Dan had Bryan fly all the way to Las Vegas for his territory review. Dan also flew Holly Burkhart from Salt Lake City into Las Vegas for her review. Holly asked if Dan would

pay for her to spend the night in Vegas since a round trip from Salt Lake City to Las Vegas all in one day was a bit exhausting. Dan told Holly that he would not be able to justify having the company pay for her room and that if she wanted to stay, she would have to pick up the cost on her own. Holly chose to fly back that same day. Dan told Bryan, however, that he would be happy to pay for his hotel room for the evening (despite the fact that it is less than a 2-hour flight from Vegas to No. CA) and that he wanted to go "out on the town" with Bryan and Tremell that evening. Having wives at home, neither of them really wanted to do this, despite the fact that Dan put tremendous pressure on them to do so. In flying Bryan all the way to Las Vegas for his review and paying for his room, not only did Dan waste Lilly dollars, he once again displayed tremendous discrimination and favoritism for the men of the team.

Q3, 2001

In the Long Term Care Division, responsibility for accounts is often a gray area. Some accounts are shared depending on what percentage of their business lies where, while others are not. During my first year in the field, I worked very closely with my pharmacy directors to determine exactly where their business comes from in order to best identify how responsibility for these accounts should be shared, if at all. Sometime during 2001, Dan Tubridy had a conversation, without my knowledge, with Robert Elorreaga of Southern California to determine how an account out of San Diego, Resource Pharmaceuticals, should be shared with Northern California. Since Resource provides all the refills to the Sunscript Pharmacy accounts in Northern California, Robert felt strongly that at least one Northern California LTC rep should share responsibility for this account. Since the Northern California Sunscript pharmacy physically sits in my geography, Dan and Robert made the decision, without my knowledge or input, to add this account to my accountability profile.

Dan never had the courtesy or professional respect to inform me of this decision. I only found out because the account mysteriously appeared in my TUR reports the next time data was sent out to the LTC reps. I called Dan immediately to ask why this account had been posted to my accountability profile. Dan explained that he and Robert made the decision based on the fact that the Northern California Sunscript account sits in my geography. I explained to Dan, (not for the first time), that although this pharmacy physically sits in my geography, only about 5% of their business actually takes place in my geography. The other 95% is completely out of my control. Which meant that of the business that Resource Pharmaceuticals handled out of San Diego, only about 2% at best actually came from my geography. Dan agreed that perhaps this account shouldn't be shared with me but that it needed to be shared with SOMEONE, and since the northern California facility lied in my territory, I was probably the best choice. After some discussion and argument, Dan finally agreed to have this account removed from my accountability profile. However, this did not occur until the beginning of Q4. Since Resource Pharmaceuticals performed poorly in Q3, it caused my performance for Zyprexa sales to come up short for Q3, dramatically impacting my professional ranking and Premier Rewards. Rather than do the fair thing which would have been to remove this account retroactively and pay me the rewards I should have been due based on the performance in my territory, the decision was made to leave the data as-is for Q3 and

basically allow me to "eat the loss." I can't stress enough how demotivated I felt after that incident.

January 23, 2002
Sales meeting in San Francisco, CA

The ladies of the team (Beth Merino, Holly Burkhart, Charmayne Rauch, and myself), Dan Tubridy, and Scott Reese went out to a nightclub called The Starlight Room. For this particular evening out, Bryan and Tremell told Dan they did not want to go. Since they were both married, and Dan always insisted on dragging them to places their wives didn't appreciate them frequenting, they decided to avoid the situation altogether by staying at the hotel. After a couple of hours (at about 11:15 p.m.), we were all ready to leave except for Dan. Our group (minus Dan who stayed behind because he was having a conversation with a strange woman at the bar) walked the two blocks back to our hotel and retired for the evening. I was rooming with Beth Merino that night. At midnight our phone rang. It was Dan asking us to come to the lobby bar to have more drinks with him. We told him we were already asleep and would not be joining him. I actually told him that he should go to bed since we had a meeting the next day. He said, "We do?" I replied, "Yes, we do." I said Goodnight and hung up the phone. Immediately after this, Dan called our administrative assistant, Charmayne Rauch, up in her room and asked her to come down to the lobby bar to have drinks with him. Charmayne asked who else was going to be down there. He lied to Charmayne, telling her that Beth and Jaye would be coming down as well (after we told him NO). Charmayne joined him and was surprised and unhappy to find out that she was alone with him. Once there, she felt obligated to entertain him and stayed for a while although she really did not desire to do so. In his drunken state, Dan confessed to Charmayne that he was unhappy in his marriage. Charmayne felt extremely uncomfortable and confessed what happened to me in confidence later in the week. Again, Dan exhibited very unprofessional behavior.

Janurary 24, 2002
Sales meeting in San Francisco, CA

Our team was scheduled to go out to dinner together. We had reservations at a restaurant for 7:00 p.m. and were to meet in the lobby at 6:30 p.m. At 6:30 p.m. Dan arrives in the lobby and announces to us ladies of the team that he, Bryan, and Tremell will be going out on their own and will see us the next day. Dan had asked Bryan and Tremell to go out with him that evening to strip clubs. Dan made the women of the team feel as though they weren't important. It was becoming more and more obvious to us that Dan favored the men of the team and that the only women he was interested in spending time with were those whose talents lied in swinging around poles on stages.

February 19, 2002
Telephone conversation between Jaye Ramirez and Dan Tubridy

I confirm with Dan that he received my e-mail suggestion for a new Long Term Care slogan for the national meeting. When he said that he did, I asked him "What did you think? Was it good?" Dan replied, "Yes Jaye, it was good. In fact, it was SO good, I have to ask you whether it is an original idea?" I felt completely insulted. I replied to

Dan, "How can you even ask me that?" I felt again as though he did not trust in me or believe me capable of being intelligent and/or creative enough to come up with an original idea.

April 1, 2002

In a telephone conversation with teammate, Bryan Zappulla, I learned that Dan, in response to a request from Bryan, is having Lilly pay to send Bryan to an upcoming American Society of Consultant Pharmacists conference in Las Vegas solely for the purpose of taking one of Bryan's customers who will be in attendance to a show. Dan is also planning on attending this show. Bryan was not one of the reps on our team chosen to win a "perk" trip this year, however Dan once again shows favoritism to the men of our team by sending Bryan on a company sponsored trip to help him build his relationship with his customer. The week prior I had actually asked Dan whether I could attend this conference since the President of the ASCP, Mark Sey, is actually one of my customers and beginning to speak for Lilly thanks to my intervention. The answer I received in response to my request to go to Vegas however was NO.

As it turns out, this trip ended up being a nightmare for Bryan, since this is the very trip where his wife, Angel Zappulla, died suddenly of an acute asthma attack. Bryan will tell you that upon return from that trip, Dan's unprofessionalism and complete lack of compassion was evident. Rather than being concerned about Bryan's mental health after this horrific tragedy, Dan was most concerned about how long Bryan was going to be out of the field and when he was coming back. In fact, the Monday after Bryan's wife died, Dan asked me by telephone whether I had talked to Bryan and if I knew when he was planning to return to the field. I found this to be appalling.

September 2002

I was given a specific dollar budget by Dan Tubridy of how much money I had to spend for expenses during Q3 of 2002. I stayed within that given budget, to the exact dollar. Just after the quarter ended, I was informed by Dan that because my expenses were not submitted and actually processed by EERS before the end of Q3, I had lost the money that was allotted to me and would have to use my allotted Q4 budget to pay for money I had spent in Q3. Because of Dan's mismanagement of our budget, I have been without any money to spend on customers during Q4. Perhaps had Dan not squandered Lilly monies earlier in the year flying reps on unnecessary trips and paying to take them to Gentleman's Clubs, we would have a little more money to spend on customers during Q4.

February 2003

Area meeting in Scottsdale, AZ. We all dressed up for the 70's themed reception our first night in town. Our team wore Afro wigs. Tremell Turner, who is African American, was sitting across the table from me at dinner. While Tremell in real life has no hair, this evening he was wearing an Afro wig like the rest of us. Dan was seated next to me. Halfway through dinner, Dan leaned over and said to me "I'll bet that's what Tremell looked like when he had hair… good thing he shaves his head!" I found this comment to be inappropriate, prejudiced, and rude. I did not reply to Dan's comment.

March 2003

This month Dan delivered a homemade presentation to the consultant pharmacists of my biggest customer, Neighborcare. The presentation was so biased, that I actually received an e-mail from Stephanie Ponedal, the lead consultant for Neighborcare, complaining about it. Stephanie said:

"Jaye, First, I need to let you know that the consultants were very unhappy with the presentation on Wednesday. My consulting group is very professional and ethical. They felt the presentation was extremely biased and did not take into account the various issues we need to deal with in our population."

Dan actually handed out a homemade upgrade recommendation letter (created by Jerry Windle of our Oakland territory) to the pharmacists. I took Stephanie out to lunch a couple of weeks later to apologize. She explained that the only reason she let us give a presentation that day was because of her respect for me and the knowledge that I would never deliver such a biased presentation. She said she was extremely disappointed with the unprofessionalism of the Lilly management team.

June 2003

I haven't documented anything in a while, but not because things do not continue to happen. I am simply tired. I have been extremely demotivated since the SPP process of last year during which I was made by Dan to be the scapegoat for this team's lack of motivation. I was accussed of "leading" the team's bad attitude toward him. It is unfortunate that he cannot see he has accomplished this all on his own.

We just returned from a quota trip during which we all felt compelled to lie to Dan's wife, Meta, who asked several of us one-on-one about why she cannot reach Dan by telephone whenever he's out of town. She asked why we drag her husband out until 4 a.m. We tried to tell her that we do not go out with him and we do not know why she cannot reach him at all hours of the night when he is out of town. She replied by stating that either we are lying or he is. We all felt extremely uncomfortable. What kind of manager would put their employees in this position?

Overall, my two-year tenure with Lilly under the leadership of Dan Tubridy has been disappointing, at best. He is, in the entire length of my adult career, the most unprofessional, insensitive, demotivating manager I have ever worked with. He is an extremely poor communicator and does not like having "difficult" conversations with his subordinates. He seeks the negative in everyone and everything. He does not possess the values that Lilly proclaims to hold in utmost importance. While Dan has excellent analytical skills, he does not have the people skills required to lead a team. In fact, in my opinion, he is a "lawsuit waiting to happen."

This team is currently at high risk of losing many of its employees within the near future, primarily due to extremely poor leadership. I regret not having come forward earlier with this information, however fear of retribution has kept me silent. I am so completely demotivated and disappointed by my experience here at Lilly over the past 2.5 years, I no longer care.

"Ponedal, Stephanie" <Stephanie.Ponedal@neighborcare.com>
03/07/2003 11:42 AM

To: "RAMIREZ_JAYE_J@LILLY.COM" <RAMIREZ_JAYE_J@LILLY.COM>
cc: "Huhn, Scott" <Scott.Huhn@neighborcare.com>
Subject: FW: Re: Visit from Dr.Sumer Verma, May 2003

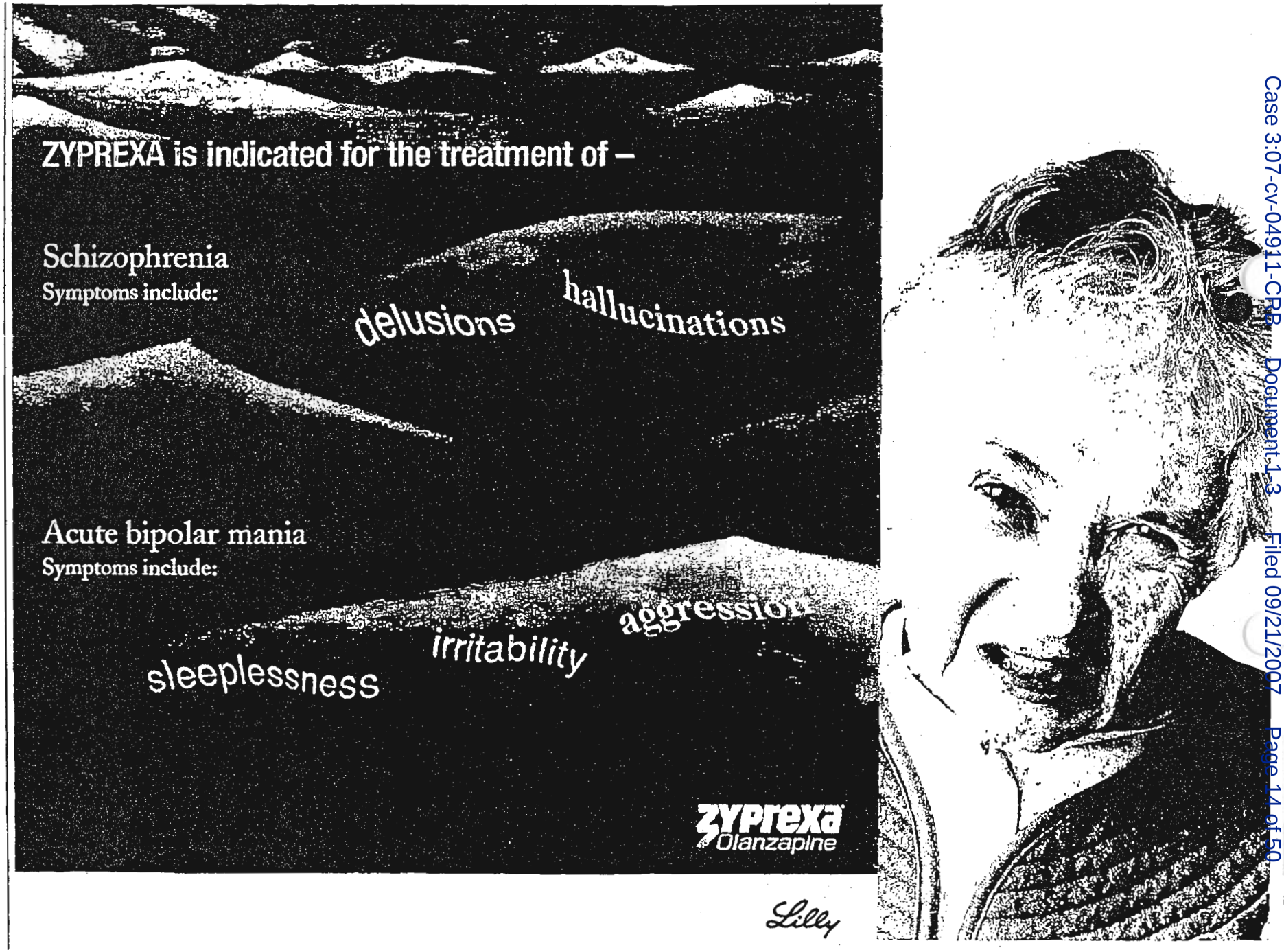
Jaye,
First, I need to let you know that the consultants were very unhappy with the presentation on Wednesday. My consulting group is very professional and ethical. They felt the presentation was extremely biased and did not take into account the various issues we need to deal with in our population.

Back t Dr. Verma, I discussed with the consultants and they thought a dinner in the Concord/Walnut Creek area would be a good idea and we could invite physicians and psychiatrists. Two or three of the consultants who live in the area could attend. It is really difficult to get all the consultants together outside of the consultant meeting. Most will not travel unless they absolutely have to since they are generally on the road all day for work.
I don't know what else you have for Dr. Verma, but if this sounds like something you want to pursue, we can talk.
Thanks,
Stephanie Ponedal

>From: RAMIREZ_JAYE_J@LILLY.COM
>To: Stephanie Ponedal <ponedal3@msn.com>
>Subject: Re: Visit from Dr.Sumer Verma, May 2003
>Date: Tue, 04 Mar 2003 20:44:58 -0500
>
>Stephanie,
>
>Per the voicemail I left for you today, Dr. Sumer Verma (credentials
>listed below) will be in the Northern California Bay Area May 14 and is
>available for a lunch or dinner with the consultants of Neighborcare.
I
>will need to know right away, however, if you would like to work with
us
>to set something up. Lilly will pay for a meal for the consultants and
>for Dr. Verma's expenses, of course. We just need to lock in an
>approximate time... either lunchtime or dinnertime. Please let me know
if
>we can work something out ASAP. Thanks!
>
>Jaye Ramirez
>
>==========
>
>Sumer Verma, M.D.
>Psychiatrist in Charge, Special Care Dementia Unit, McLean
>Hospital, Belmont, MA
>Lecturer on Psychiatry, Harvard Medical School
>Associate Professor, Department of Psychiatry, Boston University School
of
>Medicine
>
>
>

>
>
>Stephanie Ponedal <ponedal3@msn.com>
>02/25/2003 02:49 PM
>
>
> To: RAMIREZ_JAYE_J@LILLY.COM
> cc:
> Subject: Re: Visit from Dr.Sumer Verma, May 2003
>
>
>
>Hi Jaye,
>Is this still something you want to set up?
>Let me know.
>My NeighborCare e-mail is Stephanie.Ponedal@neighborcare.com
>Stephanie
>
>
>
>
>
> >From: RAMIREZ_JAYE_J@LILLY.COM
> >To: Stephanie Ponedal <ponedal3@msn.com>
> >CC: COOLEY_MERINO_ELIZABETH_M@LILLY.COM, WINDLE_JERRY_C@LILLY.COM
> >Subject: Visit from Dr.Sumer Verma, May 2003
> >Date: Wed, 23 Oct 2002 13:56:46 -0500
> >
> >Stephanie,
> >
> >Per our phone conversation this morning, Dr. Sumer Verma (credentials
> >listed below) will be in the Northern California Bay Area May 14-16,
>2003.
> >
> >
> > Sumer Verma, M.D.
> > Psychiatrist in Charge, Special Care Dementia Unit, McLean
> >Hospital, Belmont, MA
> > Lecturer on Psychiatry, Harvard Medical School
> > Associate Professor, Department of Psychiatry, Boston
University
> >School of Medicine
> >
> >We at Lilly would very much like to work with you and Neighborcare to
> >arrange a presentation to the consultants and pharmacists of
Neighborcare
> >during that time frame. Breakfast or lunch on Thursday, May 15th or
> >Friday, May 16th would be ideal.
> >
> >Please call or write me to discuss.
> >
> >Thanks!
> >
> >Jaye Ramirez
> >Neuroscience Specialist
> >Lilly Long Term Care
> >Stockton, CA
> >209-604-2649
>

EXHIBIT D



Predictable symptom control of both psychosis and elevated mood helps you **restore calm.**

Dependable maintenance of treatment response in schizophrenia helps you **bring comfort.**

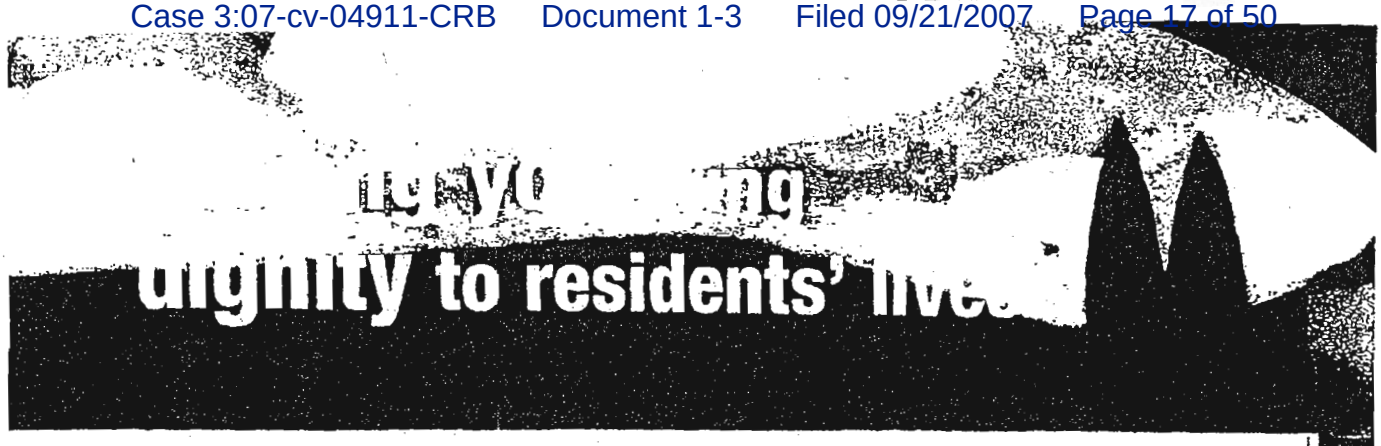
Flexible dosing helps you **customize care.**

ZYPREXA is indicated for the treatment of schizophrenia and acute bipolar mania.

Caution should be used in dosing to the elderly, especially if there are other factors that might additively influence drug metabolism and/or pharmacodynamic sensitivity.

dignity to residents' live

ZYPREXA
Olanzapine



Significantly more patients achieved higher levels of improvement in psychosis compared to risperidone[1]

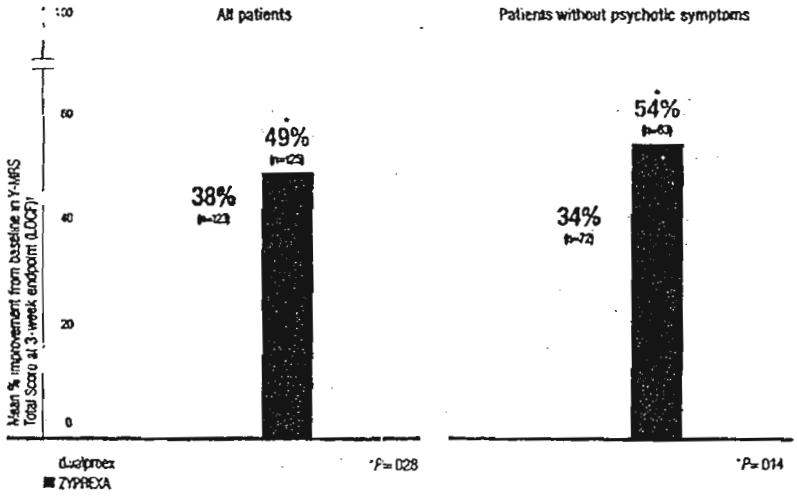
In a schizophrenia study, a significantly greater percentage of patients treated with ZYPREXA achieved an improvement of ≥40% in PANSS Total Score as compared with risperidone-treated patients. The percentage of patients achieving a 20% improvement in PANSS Total Score was comparable between treatment groups.[1]

1 Tran PV, et al. *J Clin Psychopharmacol* 1997;17:407-418.

† PANSS is Positive and Negative Syndrome Scale, consisting of 30 items.

See page 6 for more information.

Efficacy in treating symptoms of elevated mood[1,2]



In this bipolar mania study, for those with psychotic symptoms, groups treated with ZYPREXA and divalproex showed comparable improvement in Y-MRS Total Score (ZYPREXA 42%, divalproex 43%; *P*=NS).

ZYPREXA is indicated for the treatment of schizophrenia and acute bipolar mania.

For additional safety profile and other important prescribing considerations, see pages 16-17 and full Prescribing Information. Also, see pages 18-19 for Methodology and Study Limitations. For safety information on risperidone or divalproex, see manufacturers' package inserts.

Symptoms include:

IRRITABILITY

DISRUPTIVE/ AGGRESSIVE BEHAVIOR

SLEEP DISTURBANCE

1. Tohen M, et al. *Am J Psychiatry* 2002;159(6):1011-1017.
2. Data on file, Lilly Research Laboratories.

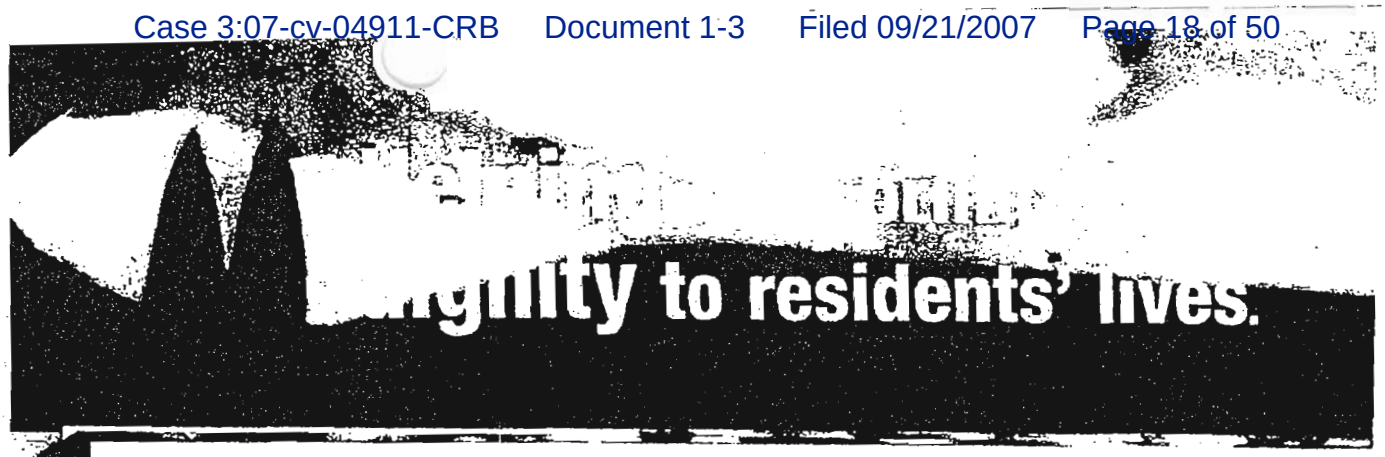
† Y-MRS is Young Mania Rating Scale, consisting of 11 items.

LOCF is Last Observation Carried Forward.

Mean modal doses were 17 mg/day for ZYPREXA and 1400 mg/day for divalproex.

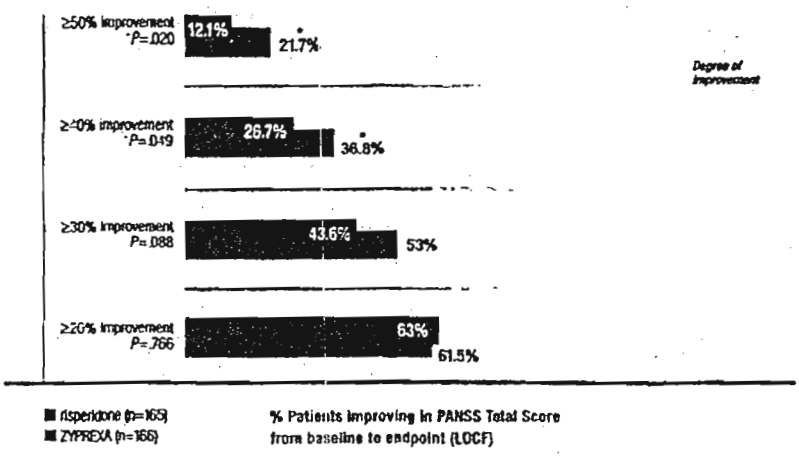
Drug Comfort Discomfort Relief

ZYPREXA Olanzapine



Predictable

Efficacy in total symptom improvement[1]



Symptoms include:

HOSTILITY

DELUSIONS

EXCITEMENT

HALLUCINATORY BEHAVIOR

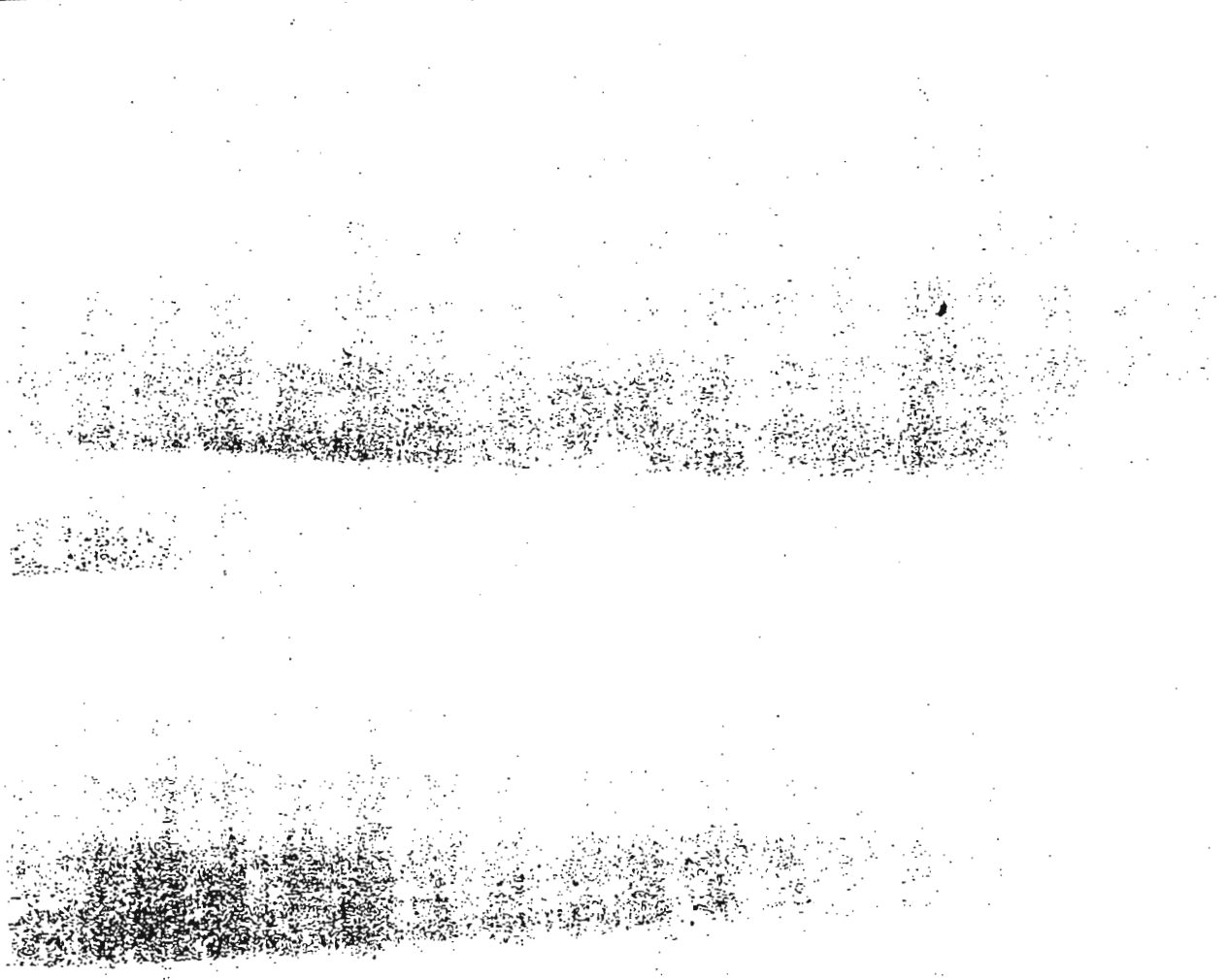
In this schizophrenia study, a significantly greater percentage of patients treated with ZYPREXA achieved an improvement of ≥40% in PANSS Total Score as compared with risperidone-treated patients.

ZYPREXA is indicated for the treatment of schizophrenia and acute bipolar mania.

For additional safety profile and other important prescribing considerations, see pages 16-17 and full Prescribing Information. Also, see pages 18-19 for Methodology and Study Limitations. For safety information on risperidone, see manufacturer's package insert.

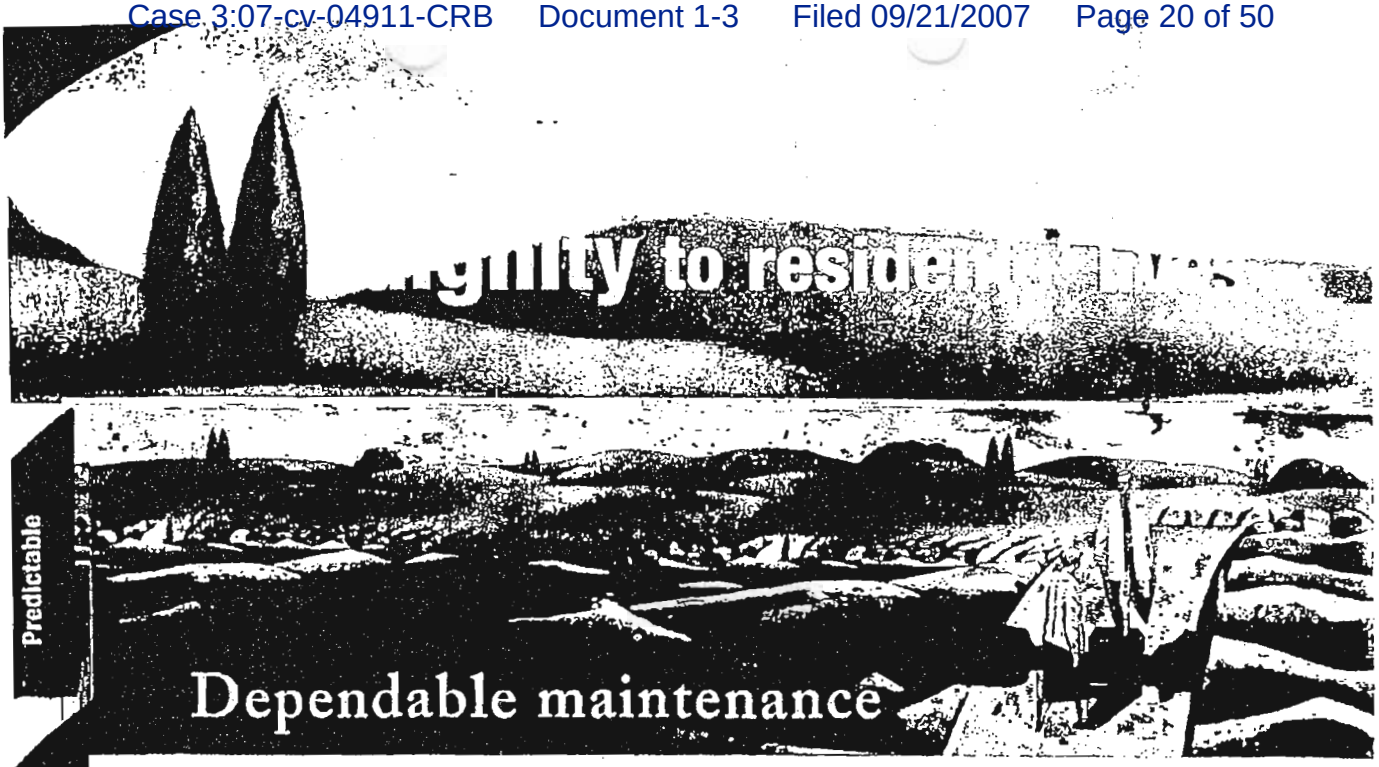
1. Tran PV, et al. *J Clin Psychopharmacol*. 1997;17:407–418.

dignity to residents' live



Bring comfort. Customize care.

zyprexa Olanzapine

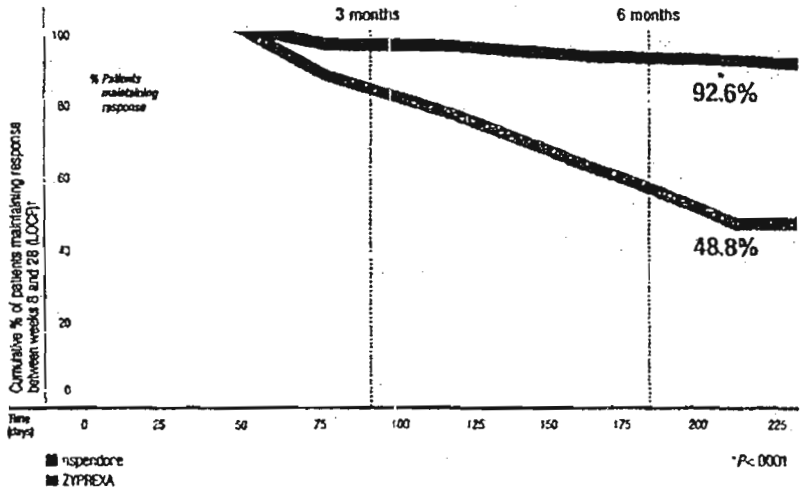


Dependable maintenance

of treatment response in schizophrenia helps you **bring comfort.**

dignity to residents' live

Superior maintenance of treatment response[1,2]



In this schizophrenia study, significantly fewer patients who reached more robust levels of improvement (≥40%) taking ZYPREXA experienced relapses at 28 weeks, compared to patients taking risperidone.

Significantly more patients taking ZYPREXA who had ≥20% improvement in PANSS Total Score at week 8 maintained their clinical response through week 28 (ZYPREXA 87.9%, n=105; risperidone 67.7%, n=94; *P*=.001).[1]

Patients should be periodically reassessed to determine the need for maintenance treatment with appropriate dose.

ZYPREXA is indicated for the treatment of schizophrenia and acute bipolar mania.

For additional safety profile and other important prescribing considerations, see pages 16-17 and full Prescribing Information. Also, see pages 18-19 for Methodology and Study Limitations. For safety information on risperidone, see manufacturer's package insert.

Understanding OBRA‡

6 months

- ✓ Reevaluate patients
- ✓ No requirement for mandatory dose reduction

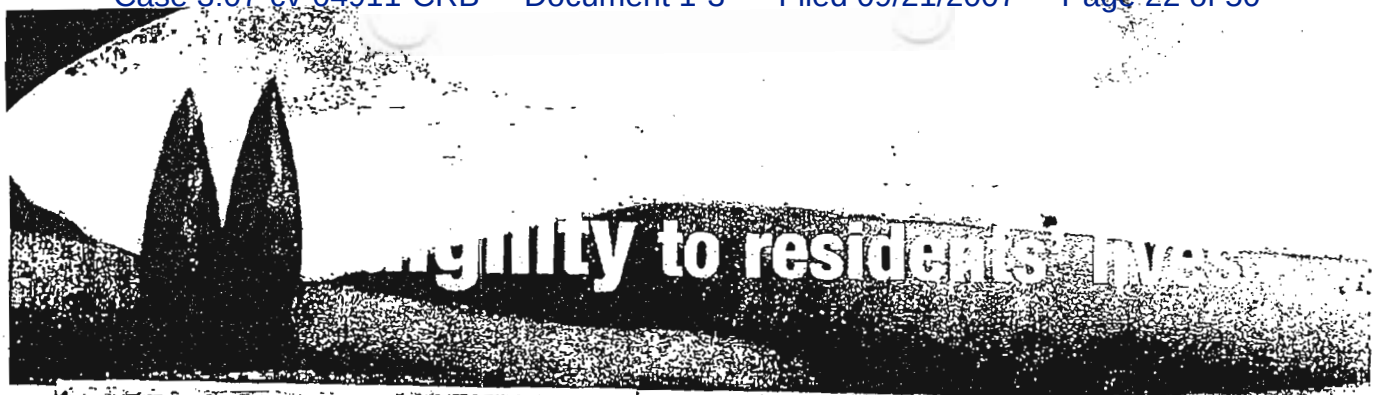
1. Tran PV, et al. *J Clin Psychopharmacol* 1997;17 407-418.
2. Data on file, Lilly Research Laboratories

† Response defined as ≥40% improvement in PANSS Total Score at week 8 (ZYPREXA n=44, risperidone n=37). Relapse defined as ≥20% worsening in PANSS Total Score plus CGI-S≥3 after 8 weeks

‡ The Omnibus Budget Reconciliation Act (OBRA) guidelines for the use of antipsychotics were released in 1987.

Customize care

zyprexa Olanzapine



Dependable

helps you **customize care.**

Flexible

dignity to residents' live

ZYPREXA tablets

Once-daily dosing without regard to meals.

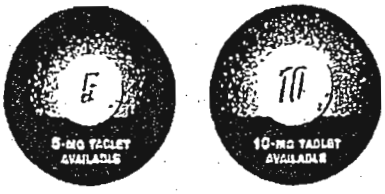
Starting dose of 5 mg recommended in patients ≥65 years of age.

ZYPREXA® Zydis® (Olanzapine) Orally Disintegrating Tablets

Quickly dissolves orally in as little as 5 seconds.

When symptoms potentially lead to noncompliance (cheekers, spitters).

When residents are having difficulty swallowing medications.



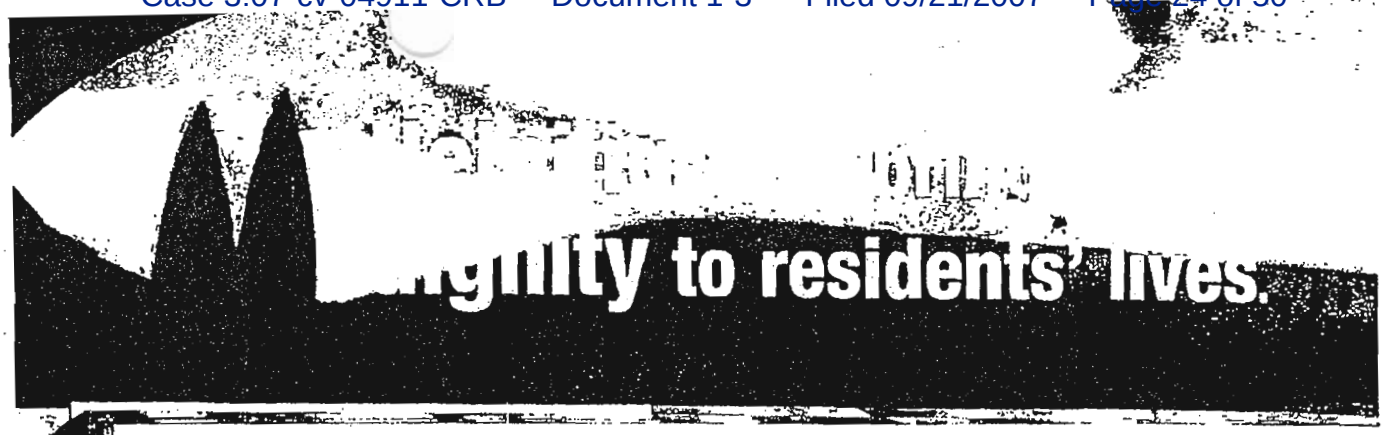
Phenylketonurics: ZYPREXA Zydis contains phenylalanine. Zydis is a registered trademark of R.P. Scherer Corporation

Caution should be used in dosing to the elderly, especially if there are other factors that might additively influence drug metabolism and/or pharmacodynamic sensitivity.

ZYPREXA is indicated for the treatment of schizophrenia and acute bipolar mania.

For additional safety profile and other important prescribing considerations, see pages 16-17 and full Prescribing Information

zyprexa



Predictable

Dependable

Flexible

Favorable safety profile

Low potential for harmful drug interactions if concomitant use is necessary

Little potential shown *in vitro* to inhibit P450 cytochromes:

valproate	warfarin	theophylline	diazepam
lithium	biperiden	imipramine	

Coadministration of diazepam or ethanol with ZYPREXA may potentiate orthostatic hypotension. Lower doses of ZYPREXA should be considered in patients receiving concomitant treatment with fluvoxamine.

Low potential for cerebrovascular accidents

Only 0.12% of patients in placebo-controlled schizophrenia registration trials (patient ages 18-94) experienced treatment-emergent CVAs (3/2500).[1]

Low potential for anticholinergic-like side effects

Incidence of common anticholinergic-like events not statistically different from placebo.[†]

Anticholinergic side effects may include: dry mouth, blurred vision, constipation, urinary retention, and increased heart rate.

No baseline ECG required

No difference in clinically significant QTc prolongation with ZYPREXA compared to placebo in premarketing clinical trials.

No routine liver or kidney function tests required

No adjustment of dosage required based upon degree of renal impairment

1. Data on file, Lilly Research Laboratories.

† In patients with schizophrenia in 2 studies who had up to 6 weeks of therapy with ZYPREXA 2.5 to 17.5 mg/day (n=248) or with placebo (n=118)

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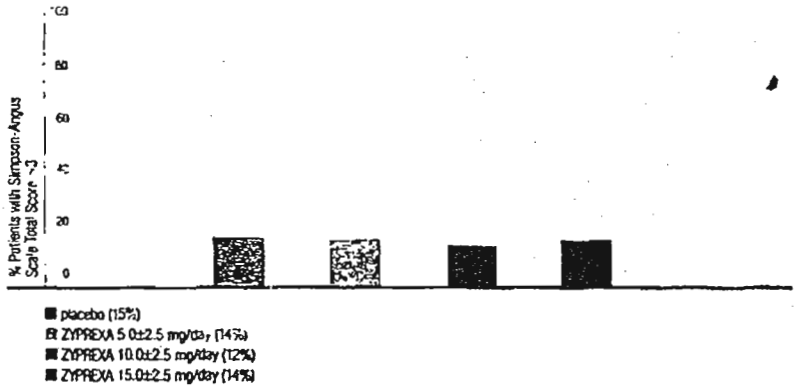
Incidence of EPS comparable to placebo



In placebo-controlled schizophrenia trials, the incidence of treatment-emergent extrapyramidal symptoms (EPS) associated with ZYPREXA was comparable to placebo,[†] as assessed by the Simpson-Angus Scale for Parkinsonism.[‡]

In only one analysis of a placebo-controlled study, only one specific form of EPS, akathisia, was reported significantly more often with ZYPREXA at any specific dose (10.0±2.5 or 15.0±2.5 mg/day) compared with placebo.

† Treatment-emergent EPS was analyzed in a double-blind, placebo-controlled comparison of ZYPREXA 5.0±2.5, 10.0±2.5 and 15.0±2.5 mg/day with placebo and haloperidol 15.0±5.0 mg/day including 335 patients with schizophrenia. Results shown are for the 6-week acute phase.

‡ No statistically significant differences vs placebo.

For additional safety profile and other important prescribing considerations, see pages 16-17 and for Prescribing Information. Also, see pages 18-19 for Methodology and Study Limitations

ZYPREXA Olanzapine

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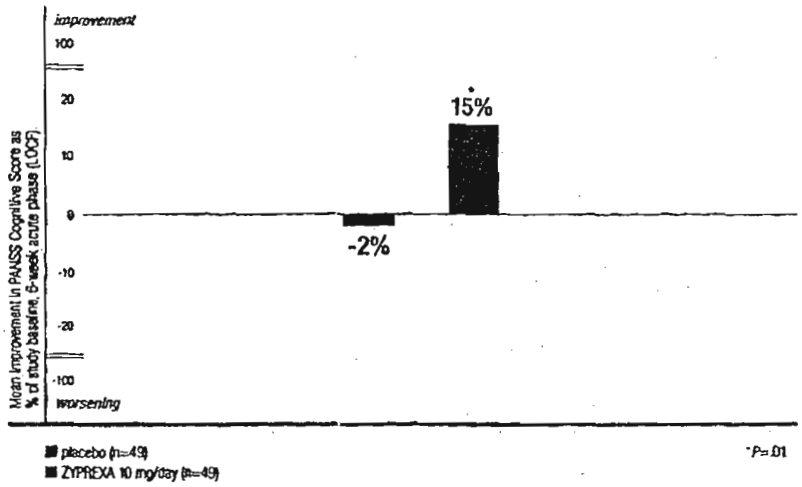
ADDITIONAL DATA

No impairment in cognition[1]



In this schizophrenia study, ZYPREXA significantly improved cognition as compared to placebo, as demonstrated by PANSS Cognitive Score.†

Including:

ATTENTION

ORGANIZED THINKING

JUDGMENT AND INSIGHT

1. Data on file, Lilly Research Laboratories.

† Results shown are from the 6-week acute phase of a double-blind comparison of ZYPREXA 1.0 and 10.0 mg/day with placebo, involving 152 patients with schizophrenia.

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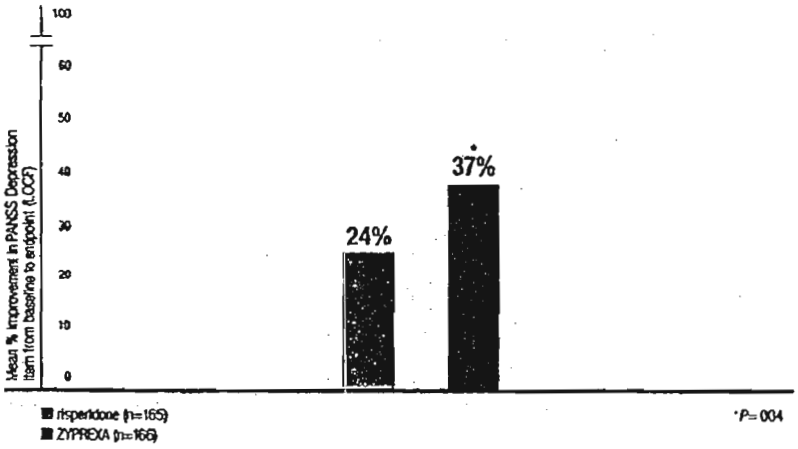
Efficacy in improving depressive symptoms[1]



Symptoms include:

SADNESS

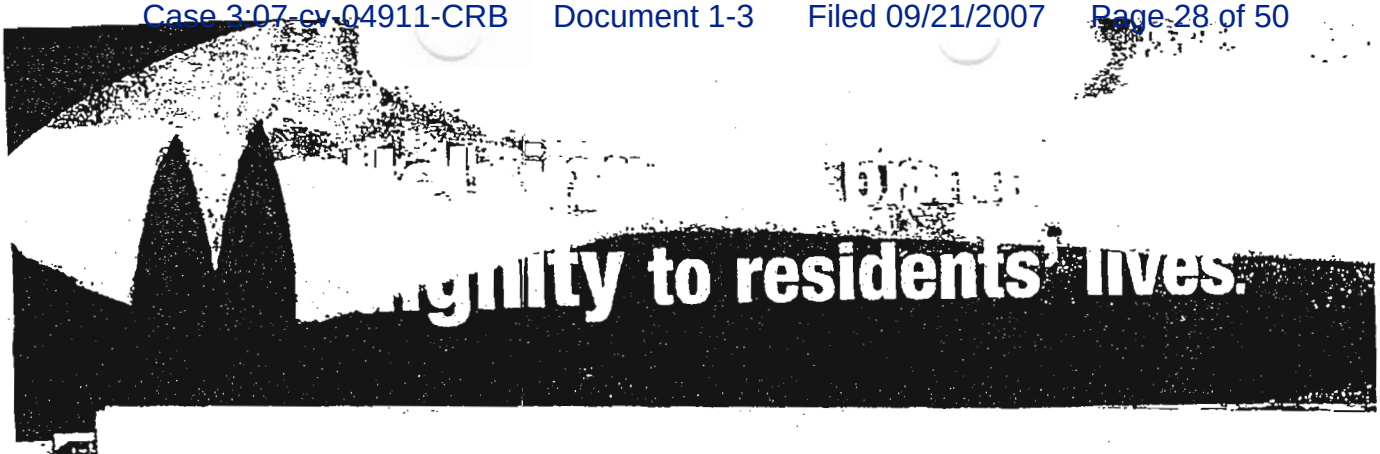
HOPELESSNESS

In this schizophrenia study, ZYPREXA was significantly more effective than risperidone in improving depressive symptoms.

For additional safety profile and other important prescribing considerations, see pages 16-17 and full Prescribing Information. Also, see pages 18-19 for Methodology and Study Limitations. For safety information on risperidone, see manufacturer's package insert.

1. Tran PV, et al. *J Clin Psychopharmacol* 1997;17:407-418.

ZYPREXA Olanzapine



Predictable Dependable Flexible

Additional prescribing considerations

The most common treatment-emergent adverse event associated with ZYPREXA vs placebo in 6-week schizophrenia trials was somnolence (26% vs 15%). Also observed (ZYPREXA vs placebo) were:

postural hypotension (5% vs 2%)
personality disorder* (8% vs 4%)
akathisia (5% vs 1%)
dizziness (11% vs 4%)
constipation (9% vs 3%)
weight gain (6% vs 1%)

The most common treatment-emergent adverse event (reported in ≥10% of patients) with ZYPREXA vs risperidone in a schizophrenia trial was somnolence (26% vs 24%). Also observed (ZYPREXA vs risperidone) were:

anxiety (19% vs 17%)
insomnia (11% vs 14%)
nausea (4% vs 10%)
weight gain (16% vs 8%)
depression (6% vs 11%)
headache (15% vs 11%)
rhinitis (9% vs 14%)

The most common treatment-emergent adverse event associated with ZYPREXA vs placebo in short-term, placebo-controlled trials in bipolar mania was somnolence† (35% vs 13%). Also observed (ZYPREXA vs placebo) were:

dry mouth† (22% vs 7%)
dizziness‡ (18% vs 6%)
asthenia‡ (15% vs 6%)
constipation (11% vs 5%)
dyspepsia (11% vs 5%)
increased appetite (6% vs 3%)
tremor (6% vs 3%)

Common and significantly different adverse events in a 3-week bipolar mania trial of ZYPREXA vs divalproex were:

somnolence (39.2% vs 20.6%)
nausea (10.4% vs 28.6%)
increased appetite (12.0% vs 2.4%)
dry mouth (33.6% vs 6.3%)

Other treatment-emergent adverse events reported in 5–10% of patients and significantly greater for ZYPREXA vs divalproex included tremor (9.6% vs 3.2%), neck rigidity (7.2% vs 1.6%), speech disorder (8.0% vs 0.8%), and sleep disorder (5.6% vs 0.8%).

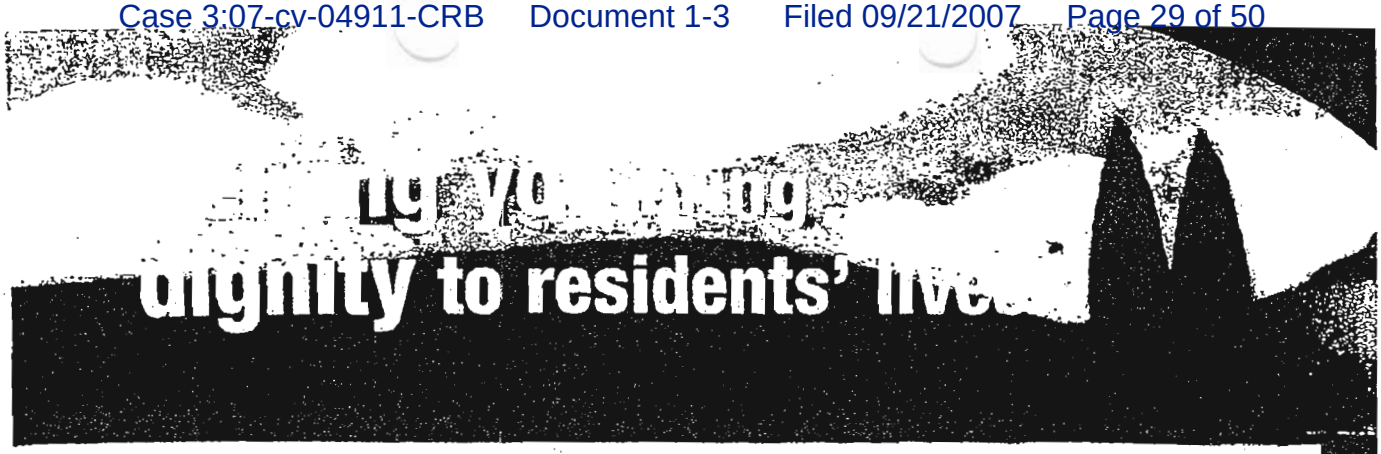
Orthostatic hypotension

In premarketing schizophrenia trials, some patients taking ZYPREXA experienced orthostatic hypotension associated with dizziness‡; tachycardia‡; and, in some cases, syncope (15/2500, 0.6%).

* COSTART term for nonaggressive objectionable behavior.

† In bipolar mania trials, 4 adverse events occurred with statistically significantly higher incidence with ZYPREXA than with placebo; none of these resulted in discontinuation.

‡ In acute-phase trials (n=366), dizziness (11% vs 4%) and tachycardia (4% vs 1%) were reported; these events were not always associated with hypotension.



Transient, asymptomatic elevations of hepatic transaminase

In placebo-controlled schizophrenia studies, clinically significant ALT (SGPT) elevations (≥3 times the upper limit of the normal range) were observed in 2% (6/243) of patients exposed to ZYPREXA compared to none (0/115) of the placebo patients. None of these patients experienced jaundice. Periodic assessment of transaminases is recommended in patients with significant hepatic disease.

As with all antipsychotic medications, the following considerations should be taken into account when prescribing ZYPREXA:

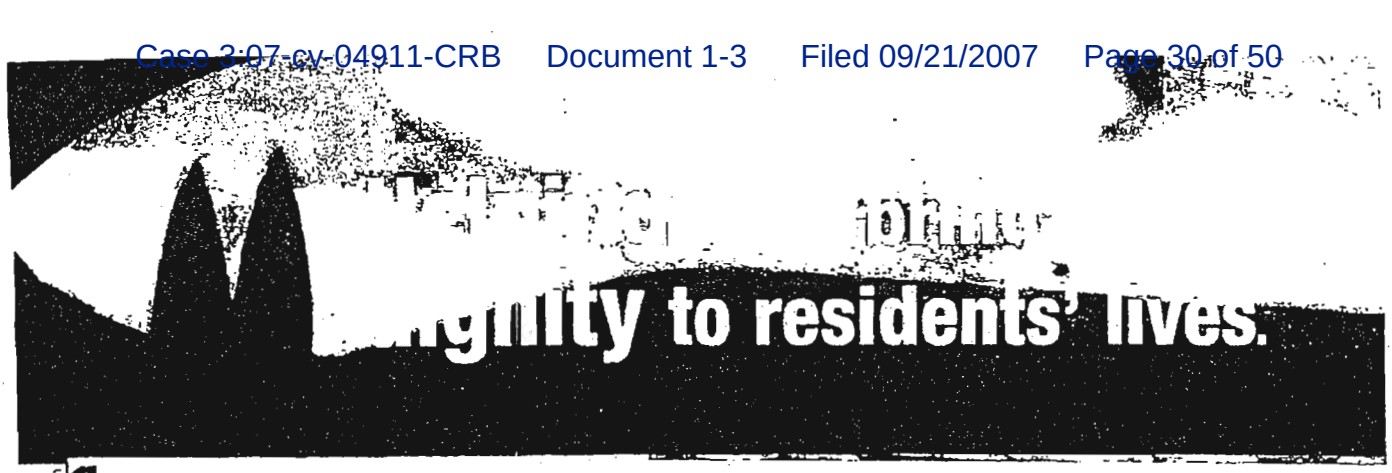
Tardive dyskinesia (TD)—prescribing should be consistent with the need to minimize the risk of TD. If its signs and symptoms appear, discontinuation should be considered.

Seizures—occurred infrequently in premarketing clinical trials of ZYPREXA (22/2500, 0.9%). Confounding factors may have contributed to many of these occurrences. ZYPREXA should be used cautiously in patients with a history of seizures or with conditions that lower the seizure threshold. Such conditions may be more prevalent in patients age 65 or older.

Use in special populations—in a clinical study involving nursing home patients having various psychiatric symptoms in association with Alzheimer's disease, somnolence, abnormal gait, fever, dehydration, and back pain were observed more often with ZYPREXA than with placebo. Of the 2500 patients in premarketing clinical studies with ZYPREXA, 11% (263) were 65 years of age or over. As with other CNS-active drugs, ZYPREXA should be used with caution in elderly patients with dementia. For patients of any age requiring special consideration, eg, patients who are debilitated, who are predisposed to hypotensive reactions, who have a combination of factors that may result in slower metabolism of ZYPREXA, or who may be more pharmacodynamically sensitive to ZYPREXA, a starting dose of 5 mg/day is recommended. When indicated, dose escalation should be performed with caution in these patients.

For additional safety profile and other important prescribing considerations, see the full Prescribing Information. For Methodology and Study Limitations, see pages 18-19.
For safety information on risperidone or divalproex, see manufacturers' package inserts.

ZYPREXA® Olanzapine



Predictable
Dependable
Flexible

Methodology and study limitations

ZYPREXA vs risperidone in schizophrenia

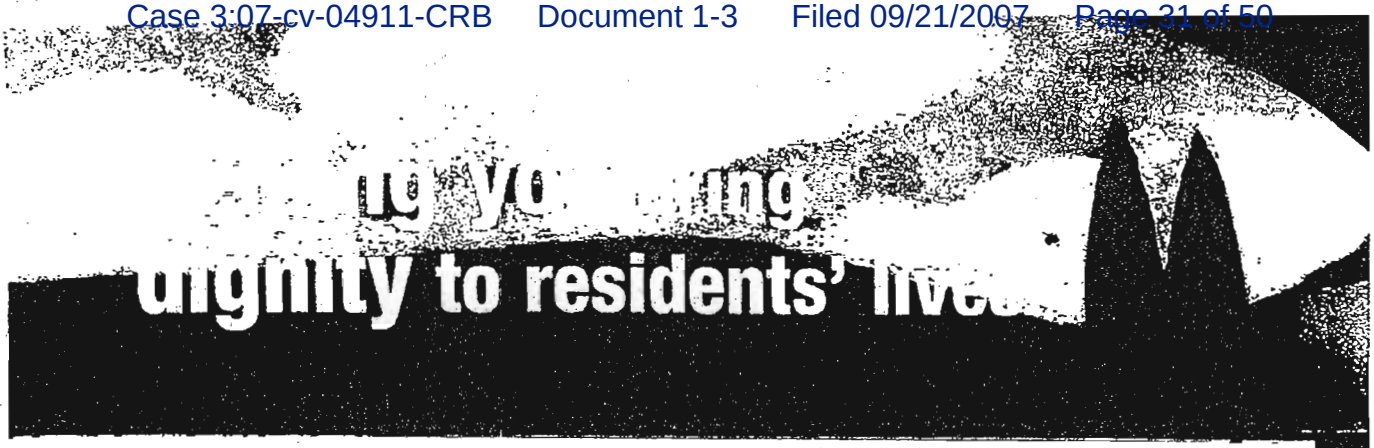
This was a double-blind, randomized, multicenter, international trial of 339 patients with schizophrenia, schizoaffective disorder, or schizophreniform disorder. Patients were randomized at a 1:1 ratio to treatment with ZYPREXA 10-20 mg/day or risperidone 4–12 mg/day. Patients enrolled in the study had the opportunity to complete 28 weeks of treatment. A total of 178 patients (52.5%) completed the study (ZYPREXA 57.6%; risperidone 47.3%; $P=.059$).

- In this flexible-dose study, patients treated with ZYPREXA initiated therapy at 15 mg/day for the first 7 days of treatment. Thereafter, investigators could adjust the daily dose upward or downward by 5 mg/day every 7 days (range 10–20 mg) as clinically indicated. The mean modal dose for ZYPREXA was 17.2 mg/day.
- Consistent with labeling, risperidone-treated patients began titration at a dose of 1 mg twice daily on day 1, 2 mg twice daily on day 2, and 3 mg twice daily on days 3 through 7. Thereafter, investigators could adjust dose upward or downward by 2 mg/day every 7 days within the approved range of 4–12 mg/day as clinically indicated. The mean modal dose for risperidone was 7.2 mg/day.
- Treatment-emergent EPS was identified based on the following criteria: Simpson-Angus Scale total score >3 at any post-baseline visit for subjects with baseline ≤3; Barnes Akathisia Scale global score ≥2 at any post-baseline visit for subjects with baseline <2.
- Patients who were previously exposed to risperidone were not excluded from this study, whereas patients previously exposed to ZYPREXA were.

ZYPREXA vs divalproex in bipolar mania

This was a double-blind, randomized, acute-phase, 3-week study conducted in 44 US sites to compare the efficacy and safety of ZYPREXA vs divalproex. 251 patients with a DSM-IV diagnosis of bipolar I disorder experiencing acute mixed or manic episodes (baseline Young Mania Rating Scale [Y-MRS] Total Score ≥20), with or without psychotic features, with or without rapid cycling courses were included.

- Dosing ranges were 5–20 mg QD for ZYPREXA and 500–2500 mg divided for divalproex, with starting daily doses at 15 mg for ZYPREXA and 750 mg for divalproex. For the 3-week trial, mean modal doses were 17 mg for ZYPREXA and 1400 mg for divalproex; mean ending doses were 17 mg QD for ZYPREXA and 1500 mg divided for divalproex. Dosing adjustments could be made after 2 days and were based on clinical response and plasma levels. Plasma levels were performed to ensure divalproex trough levels were maintained within the targeted therapeutic range of 50–125 µg/mL. Up to 4 blood samples were obtained per patient (mean, 2.7 samples); the mean value of all levels obtained was 79.4 µg/mL.



PANSS Total Score Individual Items include: delusions, conceptual disorganization, hallucinatory behavior, excitement, grandiosity, suspiciousness/persecution, hostility, blunted affect, emotional withdrawal, poor rapport, passive/apathetic social withdrawal, difficulty in abstract thinking, lack of spontaneity and flow of conversation, stereotyped thinking, somatic concern, anxiety, guilt feelings, tension, mannerisms and posturing, depression, motor retardation, uncooperativeness, unusual thought content, disorientation, poor attention, lack of judgment and insight, disturbance of volition, poor impulse control, preoccupation, and active social avoidance. The items are rated on a 7-point scale from 1 (absent) to 7 (extreme).

Y-MRS Individual Items include: elevated mood, increased motor activity/energy, sexual interest, sleep, irritability, speech (rate and amount), language/thought disorder, thought content, disruptive/aggressive behavior, appearance, and insight.

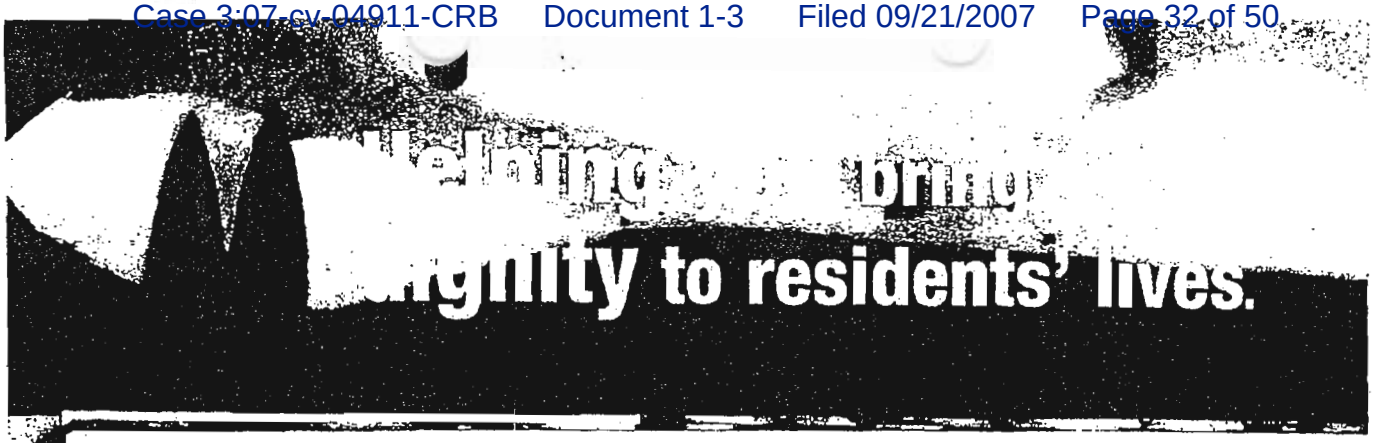
Simpson-Angus Scale for Parkinsonism is used to measure drug-induced parkinsonism. Items include: gait, arm dropping, shoulder shaking, elbow rigidity, wrist rigidity, leg pendulousness, head dropping, glabellar tap, tremor, and salivation. Items are rated on a 5-point scale from 0 (complete absence of condition) to 4 (presence of condition in extreme form).

PANSS Cognitive Score includes: conceptual disorganization, difficulty in abstract thinking, stereotyped thinking, tension, mannerisms and posturing, poor attention, and lack of judgment and insight.

PANSS Depression Item measures depressive symptoms including sadness and hopelessness.

For additional safety profile and other important prescribing considerations, see pages 16-17 and full Prescribing Information. For safety information on risperidone or divalproex, see manufacturers' package inserts.

zyprexa
Olanzapine

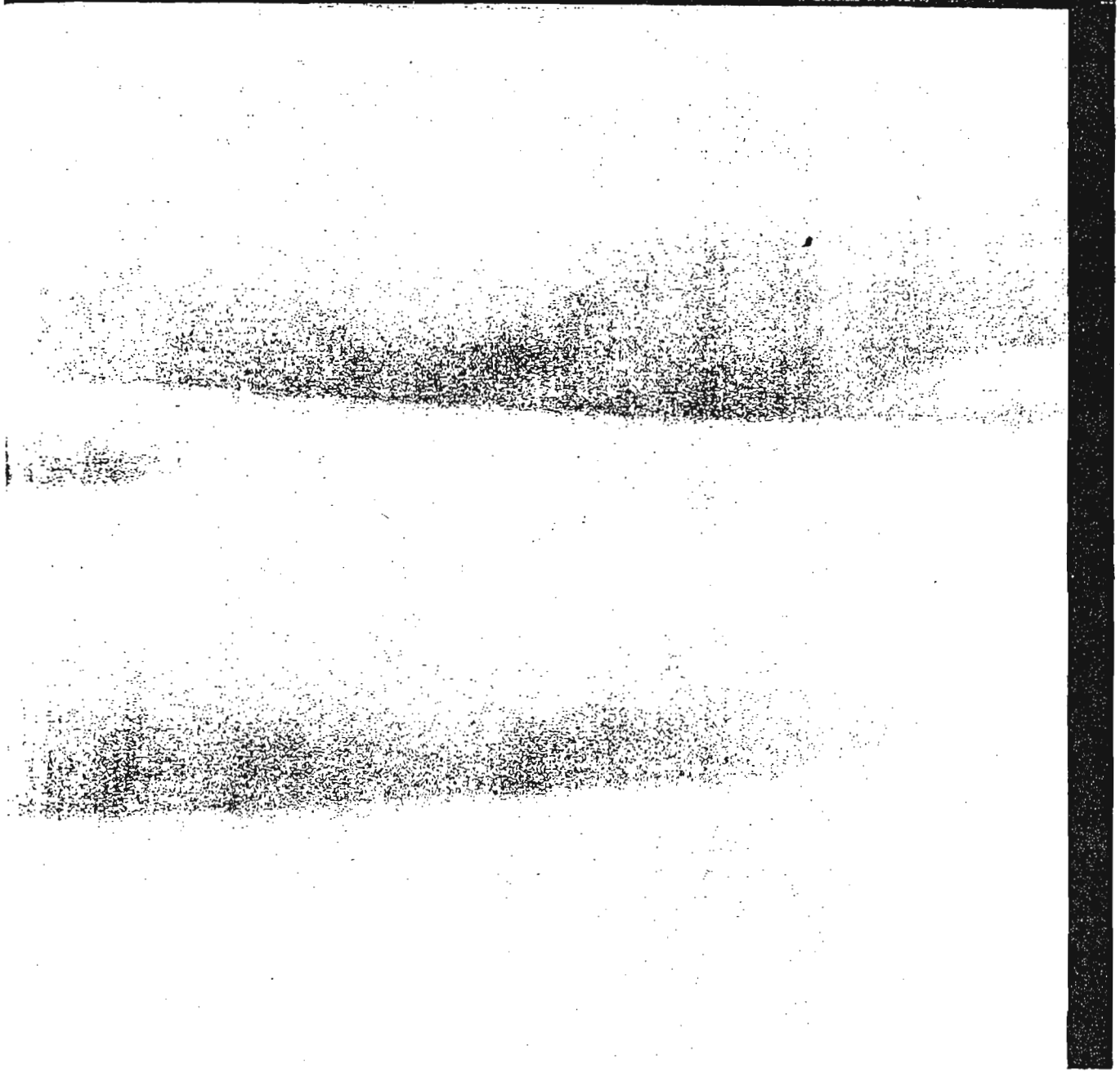


Predictable

Dependable

Flexible

dignity to residents' live

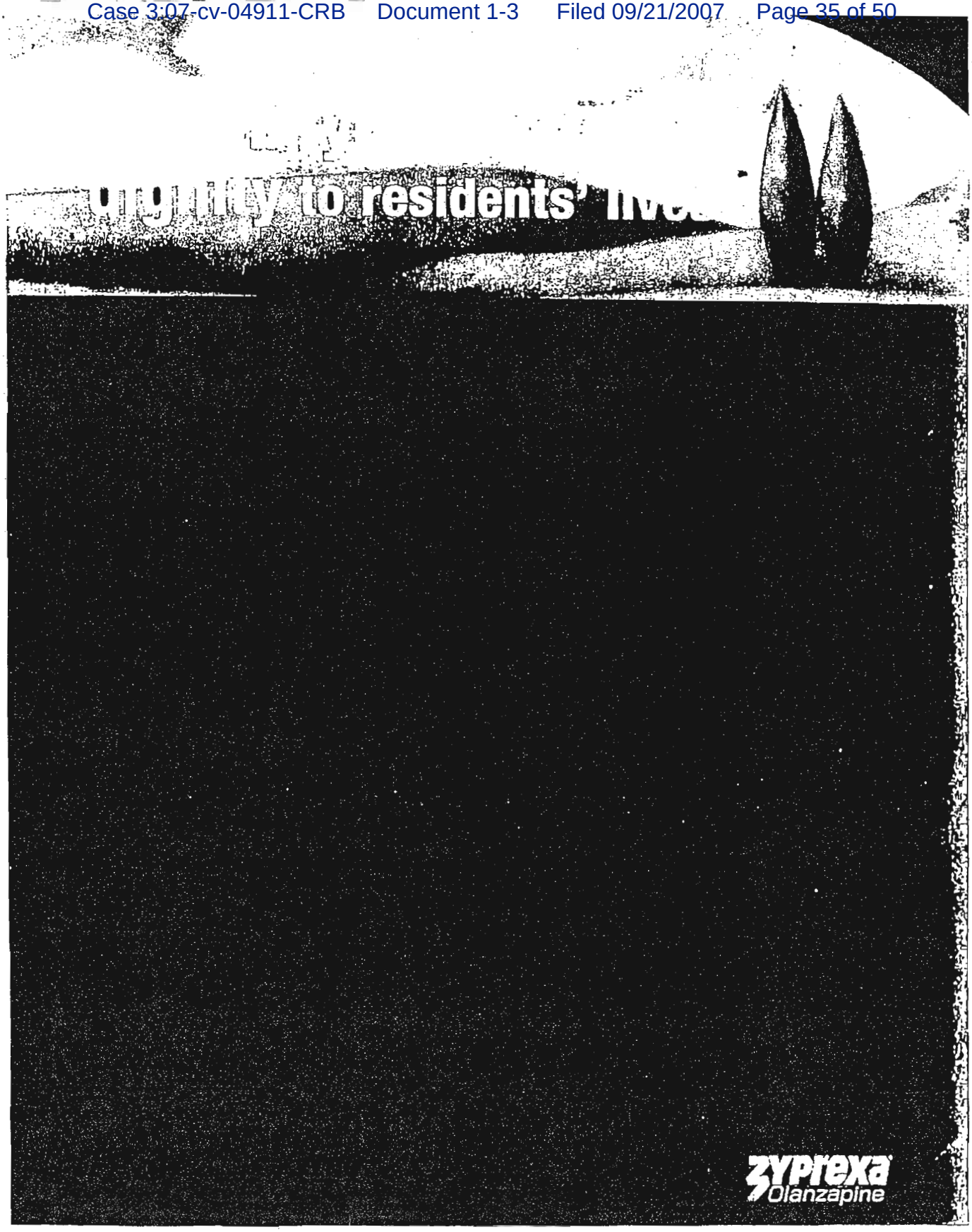


...gnity to residents' lives.

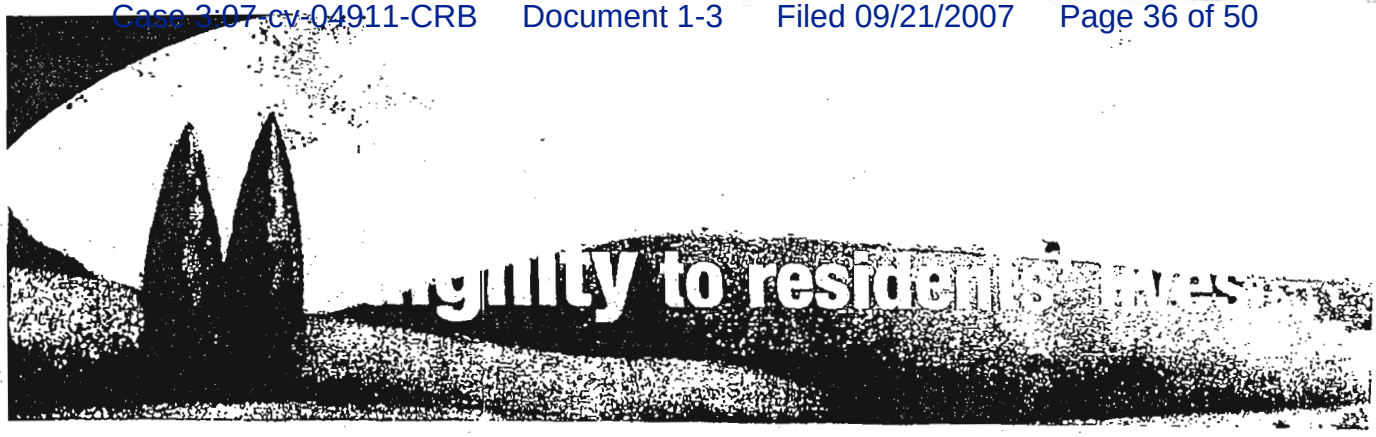
Predictable

Dependable

Flexible



Lilly



Predictable symptom control of both psychosis and elevated mood helps you **restore calm.**

Dependable maintenance of treatment response in schizophrenia helps you **bring comfort.**

Flexible dosing helps you **customize care.**

Prescribed for more than 10 million patients worldwide.

www.ZYPREXA.com

Please see accompanying full Prescribing Information.

ZYPREXA® Olanzapine

HELPING MOVE LIVES FORWARD

Lilly

EXHIBIT E

ZYPREXA LONG TERM CARE

IMPLEMENTATION GUIDE

DATA FOR 2001 SALES AID

For your information ONLY; not for use in detailing.

Zyprexa Olanzapine

Lilly

TABLE OF CONTENTS

STRATEGY OVERVIEW

The ZYPREXA Long Term Care message strategy is evolving in response to customer feedback. However, stabilizing symptoms and behaviors, maintenance of response, and safety continue to be the main drivers of the business in this setting. Message recall data indicates that we have been effective in getting both the efficacy and safety messages across to our customers. Now is the time to differentiate ZYPREXA as the product that stabilizes symptoms and behaviors safely.

The availability of comparative data versus a major competitor and the decision of the FDA to approve ZYPREXA for maintenance therapy in schizophrenia have opened a window of opportunity for us to differentiate ourselves from the competitors. Long Term Care customers are impressed with the comparative data and the fact that ZYPREXA is the first and only psychotropic to receive an indication for maintenance therapy. After all, customers are not only interested "in getting Rose better, but in keeping her better."

To effectively differentiate from the competition in both efficacy and safety, we must concentrate on the message of stabilizing symptoms and behaviors to position our product in customers' minds. Remember, we have the data to back these efficacy and safety claims, and these claims will drive business.

We want our long term care customers to believe 2 main points:

- ZYPREXA stabilizes symptoms and behaviors safely
- ZYPREXA gets patients like Rose better and keeps them better

Our Strategy

Our goal is to encourage doctors to try ZYPREXA in patients similar to the one we profile, Rose Jackson. In this way, doctors can see for themselves that ZYPREXA stabilizes symptoms and behaviors safely. They will be able to see for themselves that ZYPREXA makes patients like Rose better and keeps them better.

LONG TERM CARE DETAIL

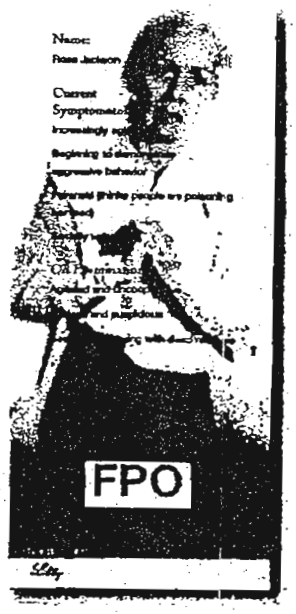
In order to help our customers believe our 2 main points, we have developed a new detail piece. It contains comparative data vs risperidone, and flows differently from our previous pieces. This message has been carefully crafted and tested to ensure that it accomplishes the following goals.

PURPOSE OF THE PIECE

- To provide the LTC team with a focused and effective message that results in action.
- To inspire our sales representatives to create a dialogue with the customer, the healthcare professional, and customize the message based on his/her knowledge and questions.
- To ensure that our customers understand the excellent product profile of ZYPREXA.
- To disseminate implementation best practices from LTC Premier Council Members.

In order to meet the fourth goal, please send your implementation best practices to your LTC Premier Council Member so we can share the learning via future implementation guides. Your LTC Brand Team is committed to ensuring that you have what you need to be successful!

THE DETAIL PIECE IS NOT TO BE LEFT BEHIND OR GIVEN TO CUSTOMERS!



PATIENT PROFILE—ROSE

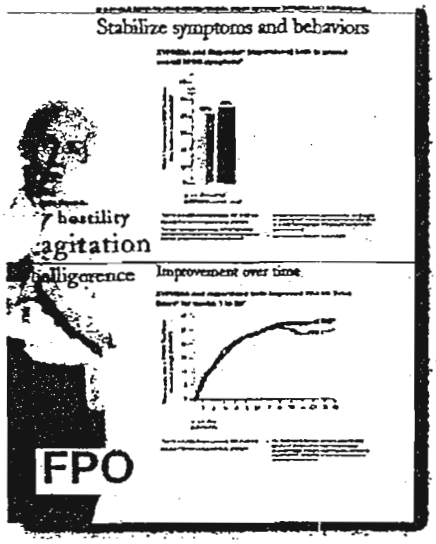
- Identify patient, Rose, and highlight her current symptomatology, clinical observations, and diagnosis.
- Depending on the setting, different symptoms may be highlighted.

Suggested Probes

- What are your goals of therapy for a patient like Rose?
- Doctor, what are you currently using with your patients like Rose?
- What kind of results are you seeing?
- Doctor, does it make sense to use ZYPREXA as a first choice for a patient like Rose, since ZYPREXA helps to safely stabilize symptoms and behaviors such as agitation, anxiety, hostility, delusions, and resistance to care?
- Doctor, if I were to show you some comparative data between ZYPREXA and another product that you are using, would you be more comfortable prescribing ZYPREXA for your patients like Rose?

Market Research

- Do not make Rose sound like an emergency patient. This will make the physician think about immediate efficacy and prescribe an IM such as Haldol or Ativan.
- The goal is to stabilize the patient's symptoms and behaviors by using a medication that is safe.



PAGE 1

TOP OF PAGE

- Doctor, this data comes from a head-to-head clinical study of 339 patients, which compared ZYPREXA vs risperidone.
- The study found that there was no difference between ZYPREXA and risperidone in stabilizing these symptoms and behaviors. (Point to symptoms.)

BOTTOM OF PAGE

- In looking at both groups' improvement scores, the study also found that both ZYPREXA and risperidone had a similar onset of action. Actually, they saw ZYPREXA beginning to separate after the sixth week. Bottom line, Doctor, it looks like both drugs had a comparable onset of action, doesn't it?

Suggested Probe

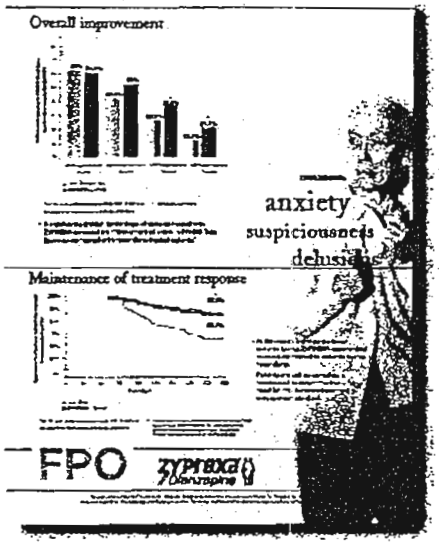
- How is this consistent with your current treatment regimen for Rose?

Market Research

- Many of our customers are not familiar with BPRS, so they appreciate when we use descriptors such as "agitation, hostility, and anger."
- Physicians do not respond well to "bashing the competition," but they do appreciate when sales representatives show comparative data between their product and a competitor.
- Some customers perceive risperidone to have better efficacy and "faster" onset of action than ZYPREXA, which is not consistent with the head-to-head data.
- The goal of the first page is to level the playing field and make the physician say; "Wow, ZYPREXA stabilizes symptoms and behaviors and has the same onset of action as risperidone."

Transitional Statement

- I would like to show you how the data on ZYPREXA differentiates from risperidone.



PAGE 2

TOP OF PAGE

- The study found a difference between ZYPREXA and risperidone with those patients who responded. This graph segments patients who had a 20%, 30%, 40%, and 50% improvement.
- When you look at those patients who had 30%, 40%, and 50% improvement, ZYPREXA stabilized symptoms and behaviors more often than risperidone.
- ZYPREXA began to separate at 30%, and at 40% and 50% it was statistically significantly better than risperidone in reducing symptoms such as anxiety, suspiciousness, and delusions.
- Doctor, does this make you more comfortable in choosing ZYPREXA for a patient like Rose, since this data suggests that you may be able to stabilize symptoms and behaviors such as anxiety, aggression, and suspiciousness?
- What additional information would demonstrate to you that ZYPREXA stabilizes symptoms and behaviors?

Transitional Statement

- Doctor, would you agree that you are not only trying to get a patient like Rose better, but also keep her better?

BOTTOM OF PAGE

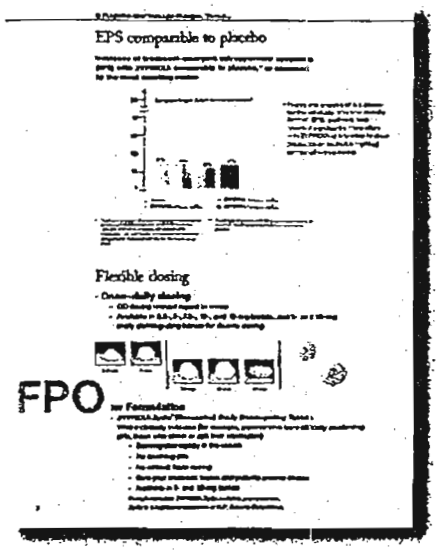
- In the same head-to-head study, physicians found that those patients who were on ZYPREXA were able to maintain their response to the medication at a higher rate than those on risperidone. Patients on ZYPREXA maintained their response at a rate of 88% for up to 28 weeks. This was 20% better than risperidone. Doctor, does it make sense that treatment is not about just getting them better, but keeping them better?
- This clinical study showed that ZYPREXA helps patients such as Rose get better, because it stabilizes her symptoms and behaviors such as anxiety, aggression and suspiciousness, and ZYPREXA keeps Rose better over time. This is why the indication for ZYPREXA has been expanded to include maintenance treatment.

Transitional Statement

- How important is this type of data for you?

MARKET RESEARCH

- Some customers do not understand the difference between PANSS and BPRS. BPRS focuses mainly on positive symptoms, whereas PANSS looks at broader symptom coverage (ie, positive, negative, depressive, and cognitive symptoms).
- Many of our customers are not familiar with PANSS, so they appreciate when we use the descriptors such as "anxiety, suspiciousness, and delusions."
- The impact of 20%, 30%, 40%, and 50% improvement must be explained to physicians in terms of what this improvement means to the patient.
- If positioned correctly, in terms of what it means to Rose, physicians respond extremely well to these 2 graphs, especially the graph containing the maintenance data.
- The goal of the second page is not to "bash" our competitors, but to differentiate ZYPREXA from risperidone.



PAGE 3

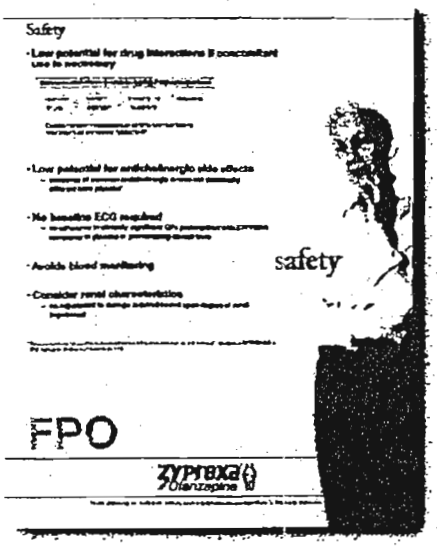
- Doctor, now that you have seen that ZYPREXA can stabilize Rose's symptoms and behaviors, let's look at the safety of ZYPREXA.
- Possibly the biggest safety concern is EPS/TD. Doctor, whether your patient needs a higher or lower dose of ZYPREXA, the risk for EPS is low. Unlike some of the products on the market today, ZYPREXA does not appear to have dose-dependent EPS.
- The once-daily dosing allows staff to administer ZYPREXA without regard to meals. Wouldn't your staff appreciate the ease of use ZYPREXA offers?
- Dosages available are 2.5-, 5-, 7.5-, 10-, and 15-mg tablets. Now you also have ZYPREXA Zydis® Orally Disintegrating Tablets for those patients who have problems swallowing pills, and those who cheek and spit their medication.
- Bottom line: ZYPREXA has dosing flexibility because you do not have to worry about dose-dependent EPS.

Suggested Probe

- Doctor, wouldn't you agree that ZYPREXA offers you true dosing flexibility? Do you have this option with products you are currently using?

Market Research

- Many of our customers were not aware that ZYPREXA had "efficacy uncompromised by excessive dose-related side effects."
- EPS is one of the major safety concerns that our customers have.



PAGE 4

- For patients like Rose who might be on multiple medications, drug interactions can be a big concern. Adding some medications might further complicate their medical state. However, the pharmacokinetics of ZYPREXA show very little potential for P450 inhibition, meaning that interaction risk is very low. So, for your patients who are taking other medications, you can safely add ZYPREXA.
- ZYPREXA has a low potential for anticholinergic side effects. For example, physicians found that the rate for constipation among patients treated with ZYPREXA was not statistically different from placebo-treated patients. Consequently, because of the favorable overall side effect profile, ZYPREXA may be a good alternative for patients at risk for these side effects.
- Cardiac adverse events are also a major concern. With ZYPREXA, there was no evidence of clinically significant QTc prolongation or other ECG changes in clinical trials.
- Another reason why ZYPREXA is easy to use is that no additional blood monitoring is required.
- The package insert for ZYPREXA states that no dose adjustment for renally impaired patients is required. So, if you have patients with this type of medical situation, ZYPREXA may have some advantages under these circumstances.
- Bottom line: ZYPREXA stabilizes symptoms and behaviors safely.

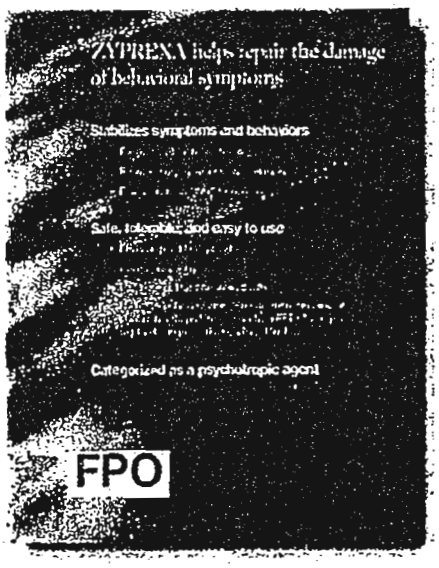
ZYPREXA Olanzapine

Suggested Probe

- Doctor, what additional data would you need to see in order to demonstrate that ZYPREXA stabilizes symptoms and behaviors safely?
- What has been your experience with the safety profiles of other products in these patients?

Market Research

- Safety or "doing no harm" is a critical reason why customers choose a product.
- Drug interactions are the number one safety concern our customers have.



PAGE 5

- C Cash in valuable chips

  Example: Doctor, you agreed that maintaining response in a patient like Rose is important. I was able to show you data from a head-to-head study which demonstrated that ZYPREXA outperformed risperidone in several respects.

- A Take action statement:

  Example: Based on the information I have shown you, does this data make a case for you to use ZYPREXA instead of risperidone in a patient like Rose?

- P Proposal (Must be an A or B option)

  Example: Doctor, how can I make this easier for you?

- S Summary (What will you do? What will the MD do? What is the time frame to get it done?)

- Doctor, I would also like to make you aware of the fact that ZYPREXA is classified by the FDA as a psychotropic, because ZYPREXA is more than just an atypical antipsychotic.

- Though OBRA Guidelines have not yet been impacted by this change yet, patients and families tell us that the psychotropic classification has less stigma than an antipsychotic does.

SHORT MESSAGE SITUATIONS

Market Research

We received positive responses from our customers who participated in Market Research for this new detail piece. This demonstrates the advantage of delivering a focused message that helps customers see that ZYPREXA stabilizes symptoms and behaviors safely. Higher message impact, higher recall of specific points (ie, maintenance, drug/drug interactions) and overall message recall were observed with this message.

- Patient profile
- Front cover
- Back cover
- Probe for an area of concern and/or follow up on the customer's previous commitment
- Respond to areas of concern
- Close using the CAPS Process; give customer a ZYPREXA dosing card (OL17251)